

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 21 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

37315

9410

Registrar's No.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				c. CITY OR TOWN <u>Belleville</u> <u>81208</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Length of stay in 1b				d. STREET ADDRESS (If outside, give location) <u>3219 Belle Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD VALLE COTTER</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER 8, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1918</u>	
9. AGE (In years last birthday) <u>39</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Murphysboro, Illinois</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Murphysboro, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Edward Cotter</u>				13b. MOTHER'S MAIDEN NAME <u>Eula Tucker</u>		14. NAME OF HUSBAND OR WIFE <u>Betty Jane Moon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes W.W.#2</u>				16. SOCIAL SECURITY NO. <u>333-01-8258</u>		17. INFORMANT Address <u>Betty Jane Cotter Belleville, Illinois</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Peritonitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Emboli to mesenteric artery</u> DUE TO (c) <u>Rheumatic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>416x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>  <u>few years</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>SEPT 23, 1957</u> to <u>OCT. 8, 1957</u> and last saw her alive on <u>OCTOBER 8, 1957</u> Death occurred at <u>5:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. D. Van Miller, M.D.</u> (Doctor or title)				22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>10/8/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>10-11-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>	
24. FUNERAL DIRECTOR <u>Brichler Funeral Home</u> ADDRESS <u>E. St. Louis, Ill.</u>				25. DATE-RECD. BY LOCAL REG. <u>OCT 9 57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mjb</u>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by not embalmed, Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Richard J. Hennel  
Ill #10, 6129  
Licensed Embalmer No. ....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting. -

If this body is not embalmed, fact should be so stated above.